MARKET CONDUCT EXAMINATION REPORT

AS OF DECEMBER 31, 2002

American Republic Insurance Company
601 Sixth Avenue
Des Moines, IA 50309

NAIC Group Code "Not Applicable"
NAIC Company Code 60836

EXAMINATION PERFORMED BY INDEPENDENT CONTRACTORS FOR

COLORADO DEPARTMENT OF REGULATORY AGENCIES
DIVISION OF INSURANCE

American Republic Insurance Company
601 Sixth Avenue
Des Moines, IA 50309

MARKET CONDUCT EXAMINATION REPORT as of December 31, 2002

Examination Performed by

Sarah S. Malloy, CIE, AIRC, PAHM, HIA
Lynn L. Zukus, AIE, FLMI

Independent Contract Examiners

November 21, 2003

The Honorable Doug Dean
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner:

This limited market conduct examination of American Republic Insurance Company was conducted pursuant to Sections 10-1-203, 10-1-204, 10-1-205(8), 10-3-1106, and 10-16-216, Colorado Revised Statutes, which authorizes the Insurance Commissioner to examine insurance companies. We examined the Company's records at its office located at 601 Sixth Avenue, Des Moines, IA 50309. The market conduct examination covered the period from January 1, 2002 through December 31, 2002.

The results of the examination are respectfully submitted by the following independent market conduct examiners.

Sarah S. Malloy, CIE, AIRC, PAHM, HIA

Lynn L. Zukus, AIE, FLMI

MARKET CONDUCT
EXAMINATION REPORT
OF
AMERICAN REPUBLIC INSURANCE COMPANY

TABLE OF CONTENTS

SECTION		PAGE
I.	COMPANY PROFILE	5
II.	PURPOSE AND SCOPE OF EXAMINATION	6
III.	EXAMINERS' METHODOLOGY	8
IV.	EXAMINATION REPORT SUMMARY	12
V.	FACTUAL FINDINGS	15
	A. Company Operations/Management	16
	E. Underwriting - Policy Forms	18
	F. Underwriting - Rating	58
	H. Underwriting - Cancellations/Non-Renewals/Declinations	61
	J. Claims	69
	K. Utilization Review	77
VI.	SUMMARY OF ISSUES AND RECOMMENDATIONS	88
VII.	EXAMINATION REPORT SUBMISSION	90

COMPANY PROFILE

American Republic Insurance Company (ARIC) was incorporated in Iowa in April 1929. It began writing business in May of the same year. Originally, only individual accident and health policies were issued. In 1951, the Company amended its Articles of Incorporation to authorize the sale of life insurance. The Company is currently licensed to do business in all states except New York. American Republic Insurance Company was licensed and began operations in Colorado in March 1946.

The Company provides both life and health products to individual markets. American Republic Insurance Company (the "Manufacturer") is committed to two core product lines, major medical and supplement insurance, predominantly Medicare supplement insurance at this time. The Company has and will continue to manufacture additional new products, such as life insurance, critical illness, and cancer products, that have been recommended as necessary and complementary to the sale of the core products. The products are offered through a nationwide agency network of career and professional producing general agents.

Effective December 1999, American Republic Mutual Holding Company, a mutual insurance holding company was formed in accordance with the laws of the State of Iowa. American Republic Mutual Holding Company owns 100% of the common stock of American Republic Group Inc., an intermediate stock company also formed in December 1999. ARIC became a stock company in December 1999 and has 100% of its common stock owned by the Group.

ARIC has two wholly owned subsidiaries, American Republic Equities and Americare Marketing, LLC. American Republic Equities is a registered broker/dealer and its current activities are limited to servicing ARIC's existing variable annuity business. Americare Marketing, LLC was formed to offer various non-insurance services to ARIC customers.

The Company's Accident and Health direct written premium in Colorado for 2002 was $20,410,000, representing 1.16% of the market share. The Company's loss ratio in Colorado for 2002 was 66.67%.

Best's Insurance Reports – L/H, 2002 Edition assigned a Best's Rating of A- (Excellent) to American Republic Insurance Company.

PURPOSE AND SCOPE OF EXAMINATION

Independent examiners, contracting with the Colorado Division of Insurance (DOI), in accordance with Sections 10-1-202, 10-1-203, 10-1-204, C.R.S., which empowers the Commissioner to require any company, entity, or new applicant to be examined, reviewed certain business practices of American Republic Insurance Company. The findings in this report, including all work products developed in producing it, are the sole property of the Colorado Division of Insurance.

The purpose of the limited examination was to determine the Company's compliance with Colorado insurance law and with generally accepted operating principles related to individual sickness and accident insurance. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record. The preceding statements are not intended to limit or restrict the distribution of this report.

Examiners conducted the limited examination in accordance with procedures developed by the Colorado Division of Insurance, based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained by the Company. The market conduct examination covered the period from January 1, 2002 through December 31, 2002.

The limited examination included review of the following:

Company Operations/Management
Policy Forms
Rating
Applications
Cancellations/Non-Renewals/Declinations
Claims
Utilization Review

The final exam report is a report written by exception. References to additional practices, procedures, or files that did not contain improprieties were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms contain a section that permits the Company to submit a written response to the examiners' comments.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero ($0) tolerance level was applied in order to identify possible system errors. Additionally a zero ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

When sampling was involved, a minimum error tolerance level of five percent (5%) was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the examination (e.g. timeliness of claims payment), and if one or more of the samples yielded an exception

rate of five percent (5%) or more, the results of any other samples with exception percentages less than five percent (5%) were also included.

For the period under examination, the examiners included statutory citations and regulatory references related to individual insurance laws. Examination findings may result in administrative action by the Division of Insurance. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance company or insurance product.

EXAMINERS' METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws and Colorado regulations. For this examination, special emphasis was given to the laws and regulations as shown in Exhibit 1.

Exhibit 1

Law/Regulation	Concerning
Section 10-1-101-10-1-130	General Provisions
Section 10-3-1104	Unfair methods of competition and unfair or deceptive acts or practices
Section 10-8-513	Eligibility for coverage under the program
Section 10-8-521	Notice to residents
Section 10-8-601.5	Applicability and Scope
Section 10-8-602	Definitions
Section 10-16-101-10-16-121	Colorado Health Care Coverage Act: Part I: Short Title - Definitions - General Provisions
Section 10-16-201-10-16-219	Sickness and Accident Insurance
Section 10-16-701-10-16-708	Consumer Protection Standards Act for the Operation of Managed Care Plans
Section 10-20-102	Legislative declaration
Section 10-20-103	Definitions
Amended Regulation 1-1-6	Concerning the Elements of Certification for Accident and Health Forms, Automobile Private Passenger Forms, and Claims-Made Liability Forms
Regulation 1-1-7	Market Conduct Record Retention
New Regulation 1-1-8	Penalties And Timelines Concerning Division Inquiries And Document Requests
Repromulgated Regulation 4-2-1	Replacement Of Accident And Sickness Insurance
Regulation 4-2-5	Hospital Definition
Amended Regulation 4-2-6	Concerning The Definition Of The Term "Complications Of Pregnancy"
Amended Regulation 4-2-8	Concerning Required Health Insurance Benefits for Home Health Services and Hospice Care
Amended Regulation 4-2-11	Rate Filing and Annual Report Submissions Health Insurance
Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Amended Regulation 4-2-17	Prompt Investigation of Health Plan Claims Involving Utilization Review

Amended Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-existing Conditions
Amended Regulation 4-2-20	Concerning The Colorado Comprehensive Health Benefit Plan Description Form
New Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Amended Regulation 4-6-3	Concerning CoverColorado Standardized Notice Form And Eligibility Requirements
Amended Regulation 4-6-5	Implementation of Basic and Standard Health Benefit Plans
Regulation 4-6-9	Conversion Coverage
Amended Regulation 5-2-3	Auto Accident Reparations Act (No-Fault) Rules and Regulations

Company Operations/Management

The examiners reviewed Company management and administrative controls, the Certificate of Authority, record retention, and timely cooperation with the examination process.

Policy Forms

The examiners reviewed the following Policy Forms, Application, Endorsements and Rider Forms.

FORM NUMBER	FORM NAME
A-3173CO	Major Medical Expense Base Policy
A-3173CO-113	Policy Data Page
A-3054-M	Application For Health Insurance
A-3322CO	Optional Accident Expense Benefit Endorsement
A-3563CO	PPO Benefit Endorsement
A-3564CO	Reducing Coinsurance Amount Endorsement
A-3566CO	Wellness Endorsement
A-3567CO	Outpatient Prescription Drug Endorsement
A-2803CO	Endorsement - Child Health Supervision Services Benefits
A-3565CO	Doctor Office Visit Endorsement
A-3562CO	Preferred Provider Endorsement (80% & 70% plans)
A-3472CO	Endorsement to remove Pre-authorization
A-3499CO	Endorsement - Notice of Grievance Procedures
A-3054-M	Major Medical Application
F-1015	Applicant Disclosure for Business Groups of One
113 0454 CO	Notice To Applicant Regarding Replacement
F-1022	HIPAA Qualification Form
A-2307CO 2-94	Endorsement – Home Health Care Benefit
A-2562CO 2-94	Endorsement – Hospice Care Services Benefit

The most frequently sold individual plan in Colorado in 2002 was the UltraCare Preferred 1, Form A-3173CO.

Rating

The examiners reviewed a systematically selected sample of the rates charged in the sample of files used in the Underwriting-Application section of the examination. These rates were reviewed for compliance with the rate filings submitted to the Colorado Division of Insurance as the rates being used during the examination period.

Applications

For cases that were initially effective or renewed during the period from January 1, 2002 through December 31, 2002, the examiners used ACL™ software to systematically select 100 individual (50 new and 50 renewal business) application files. These files were reviewed for compliance with Colorado insurance law.

Cancellations/Non-Renewals/Declinations

For individual cases that terminated (were cancelled, non-renewed, rescinded or declined) during the period under examination, the examiners used ACL™ software to systematically select a sample of fifty (50) cancelled/non-renewed files and fifty (50) declined files. The population of thirteen (13) rescinded files was used as the sample. These files were reviewed to determine if the procedures used for cancellations, non-renewals, declinations and rescissions were in compliance with Colorado insurance law and contractual obligations.

Claims

The examiners used ACL™ software to systematically select samples of electronically received and non-electronically received individual claims that were reviewed for timeliness of processing only. Additionally, any claims absent fraud that were not paid, denied or settled within ninety (90) days of receipt were identified. Valid exceptions in all of these categories were included in one issue.

The examiners used ACL™ software to systematically select samples of 100 Paid claims and 100 Denied claims that were reviewed for the Company's overall claims handling practices. The Company had changed its claims system to create one file per claim as of June 2002 and indicated that providing data to be used in this examination that produced one record for each paid claim was not possible for claims received prior to June 2002. As a result, the Division of Insurance and the Company agreed to use only claims received during the last six months of 2002 for this examination.

Utilization Review

The Company used ENCOMPASS to process Utilization Review cases for the state of Colorado during 2002. The Company indicated there were only five (5) review decisions during 2002. These involved approval of two (2) concurrent admission reviews, two (2) continued stay reviews and one (1) prospective admission review. The Company indicated that there were no adverse determinations or

reconsiderations processed. The five (5) files were reviewed for compliance with Colorado insurance law, and in addition the examiners reviewed the Company's utilization management procedures and policies.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of twenty-seven (27) findings in which the Company did not appear to be in compliance with Colorado Statutes and Regulations. The following is a summary of the examiners' findings and recommendations.

- **Company Operations/Management:** The examiners found one (1) areas of concern in their review of company operations and management. The following issues were identified:

  1. Certifying and using forms that do not comply with Colorado insurance law.

  It is recommended that the Company develop, implement, and monitor the necessary procedures to ensure that all forms to be issued or delivered to Colorado insureds comply with statutory mandates as certified to by an officer of the Company.

- **Policy Forms:** The examiners found sixteen (16) areas of concern in their review of the most frequently sold individual policy forms in use during the year under examination. The following issues were identified:

  1. Failure to include a complete description of the independent external review procedures in or attached to the policy.

  2. Failure to reflect only allowable reasons for non-renewal of plans.

  3. Failure of the forms to provide benefits for covered services based on a provider's status as a family member.

  4. Failure to reflect correct information in a policy provision required for individual policies.

  5. Failure to reflect complete information in application forms concerning replacement of coverage.

  6. Failure to reflect a correct definition of a Business Group of One in an Applicant Disclosure Form.

  7. Failure to reflect correct or complete information in the CoverColorado Notice Form.

  8. Failure to reflect correct and complete coverage to be provided for Home Health Care Services.

  9. Failure to reflect correctly and completely the extent of coverage to be provided for hospice care services.

  10. Failure to disclose mandated hospitalization and general anesthesia benefit for dental procedures for dependent children.

11. Failure to reflect that repairs and replacement of prosthetic devices, unless due to misuse or loss, are to be covered.

12. Failure to reflect complete mandated preventive child health supervision service benefits.

13. Failure to reflect an accurate or complete description of the mandated therapies for congenital defects and birth abnormalities for children.

14. Failure to provide coverage for routine hospital nursery care for newborns.

15. Failure to reflect an accurate description of the mandated coverage for prostate cancer screening.

16. Failure to reflect correct benefits for mammography screening.

It is recommended that the Company review and revise all applicable policy forms to comply with individual sickness and accident laws and regulations.

- **Rating:** The examiners found one (1) area of concern in their review of the rates and associated required rate filings.

  1. Failure, in some instances, to refrain from unfair discrimination involving rates used for new business and, in some instances, to use the rates filed with the Colorado Division of Insurance.

  It is recommended that the Company establish procedures to ensure that filed rates are used and that they are used as of the effective date stated in its filings with the Colorado Division of Insurance.

- **Applications:** The examiners found no areas of concern in their review of application files for the examination period.

- **Cancellations/Non-Renewals/Declinations:** The examiners found three (3) areas of concern during the review of the cancellation/non-renewal/declination files. The following issues were identified:

  1. Failure to provide CoverColorado notice forms in all required instances.

  2. Failure, in some cases, to issue Certificates of Creditable Coverage.

  3. Failure, in some instances, to use non-discriminatory practices and use of unfair claim settlement practices in some instances involving rescission of coverage.

  It is recommended that the Company establish procedures to ensure that CoverColorado notice forms and Certificates of Creditable Coverage are issued in all cases. Procedures should also be established to ensure that any discriminatory or unfair claim settlement practices evident in procedures for rescinding coverage are eliminated.

- **Claims:** The examiners found four (4) areas of concern in their review of the claims handling practices of the Company. The following issues were identified:

  1. Failure, in some cases, to pay, deny or settle claims within the time periods required by Colorado insurance law.

  2. Failure to accurately determine the number of days utilized for claim processing.

  3. Failure, in some instances, to pay late payment penalties on claims.

  4. Failure to have available a mechanism for providers to confirm receipt of a claim or to determine if resubmission of a claim is necessary.

  It is recommended that the Company establish procedures to ensure payment, denial or settlement of claims within the time frames required by law. Procedures should also be established to ensure that the number of days utilized for claim processing is calculated correctly and that late payment penalties are paid in all required instances. It is recommended that a mechanism be established that enables providers to confirm receipt of a claim or determine if resubmission of a claim is necessary.

- **Utilization Review:** The examiners found two (2) areas of concern in their review of utilization review procedures. The following issues were identified:

  1. Failure to reflect correct or complete information for second level appeals or external review rights.

  2. Failure to include all required information in notification letters for first level appeal determinations.

  It is recommended that the Company review and revise its Utilization Review procedures to ensure they comply with Colorado insurance law.

A copy of the Company's response, if applicable, can be obtained by contacting the Company or the Colorado Division of Insurance.

Results of previous Market Conduct Exams are available on the Colorado Division of Insurance's website at www.dora.state.co.us/insurance or by contacting the Colorado Division of Insurance.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

AMERICAN REPUBLIC INSURANCE COMPANY

COMPANY OPERATIONS / MANAGEMENT FINDINGS

Issue A1: Certifying and using forms that do not comply with Colorado insurance law.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

> (1)(s) Certifying pursuant to section 10-16-107.2 or issuing, soliciting, or using a policy form, endorsement, or rider that does not comply with statutory mandates. Such solicitation or certification shall be subject to the sanctions described in sections 10-2-704, 10-2-801, 10-2-804, 10-3-1107, 10-3-1108, and 10-3-1109.

An officer of the Company must certify compliance with Colorado insurance law with all initial filings of policy forms and on the annual report of policy forms. It appears that the Company is not in compliance with Colorado insurance law in that not all forms that were certified and used by the Company were in compliance with statutory mandates as evidenced by Issues E1 through E16.

Recommendation No. 1:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-3-1104, C.R. S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that evidence of coverage forms to be issued or delivered to Colorado insureds comply with statutory mandates as certified to by an officer of the Company, and as required by Colorado insurance law.

UNDERWRITING
POLICY FORMS
FINDINGS

Issue E1: Failure to include a complete description of the independent external review procedures in or attached to the policy.

New Regulation 4-2-21, External Review of Benefit Denials of Health Coverage Plans, promulgated and adopted by the commissioner of Insurance under the authority of §10-1-109, 10-16-109, 10-16-113(3)(b) and 10-16-113.5(4)(d), C.R.S., states:

> Section 5. Notice and Disclosure of Right to External Review
>
> B. (1) Effective for policies issued or renewed on or after June 1, 2000, each carrier shall include a description of the external review procedures *in or attached* to all health coverage plan materials dealing with the plan's grievance procedures including but limited to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to covered persons. [Emphasis added.]
>
> (2) The description required under (1) of this Subsection B shall include a notification of the availability of an external review process, *the circumstances under which a covered person may use the external review process, the procedures for requesting an external review, and the timelines associated with an external review*. [Emphasis added.]

The Company does not appear to be in compliance with Colorado insurance law with regards to including a complete description of the external review procedures in or attached to all health coverage plan materials dealing with the plan's grievance procedures. The Notice of Grievance Procedures endorsement attached to the policy only informs covered persons of their right to request an external review from the Company.

The wording reflected in the endorsement is:

> NOTICE OF GRIEVANCE PROCEDURES
>
> The grievance procedures consist of a two-level internal review of the decision, followed by your right to request an external review. To obtain a copy of the grievance procedures, please submit your written request to:
>
> Grievance Coordinator
> American Republic Insurance Company
> 601 6th Ave.
> Des Moines, Iowa 50309

Form Number	Form Name
A-3499CO	NOTICE OF GRIEVANCE PROCEDURES

Recommendation No. 2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of New Regulation 4-2-21. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that a complete description of external review procedures is in or attached to all health coverage plan materials dealing with grievance procedures as required by Colorado insurance law.

Issue E2: Failure to reflect only allowable reasons for non-renewal of plans.

Section 10-16-201.5, C.R.S., Renewability of health benefit plans – modification of health benefit plans, states:

> (1) A carrier providing coverage under a health benefit plan shall not discontinue coverage *or refuse to renew such plan except for the following reasons*: [Emphasis added.]
>
> (a) Nonpayment of the required premium;
> (b) Fraud or intentional misrepresentation of material fact on the part of the plan sponsor with respect to group health benefit plan coverage and the individual with respect to individual coverage;
> (d)(I) The carrier elects to discontinue offering and nonrenew all of its individual, small group, or large group health benefit plans delivered or issued for delivery in this state. In such case the carrier shall provide notice of the decision to discontinue or not to renew coverage to all policyholders and covered persons and to the insurance commissioner in each state in which an affected individual is known to reside at least one hundred eighty days prior to the discontinuance or nonrenewal of the health benefit plan by the carrier. The carrier shall also discontinue and nonrenew all of its individual or small or large group health benefit plans in Colorado. Notice to the insurance commissioner under this paragraph (d) shall be provided at least three working days prior to the notice to the affected individuals.
>
> (4) An individual health benefit plan must clearly disclose in its contracts and marketing materials the conditions of renewability which conform with the requirements of this section.

The Company's most frequently sold plan in Colorado in 2002, does not appear to reflect only allowable reasons for non-renewal of individual plans.

The wording on page one is:

> **RENEWABILITY** … We can refuse to renew this policy on any policy renewal date if: (c) other insurance results in the duplication of benefits or overinsurance on any covered person.

Form Number	Form Name
A-3173CO	Major Medical Expense Policy

Recommendation No. 3:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-201.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its individual policy forms to ensure compliance with Colorado insurance law in reflecting only allowable reasons for non-renewal of plans.

Issue E3: Failure of the forms to provide benefits for covered services based on a provider's status as a family member.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(7) Reimbursement of providers

(a) Sickness and accident insurance.

(I)(A) Notwithstanding any provisions of any policy of sickness and accident insurance issued by an entity subject to the provisions of part 2 of this article or a prepaid dental care plan subject to the provisions of part 5 of this article, whenever any such policy or plan provides for reimbursement for any service that may be lawfully performed by a person licensed in this state for the practice of osteopathy, medicine, dentistry, dental hygiene, optometry, psychology, chiropractic, or podiatry, reimbursement under such policy or plan shall not be denied when such service is rendered by a person so licensed. …

The Company's most frequently sold policy in Colorado in 2002 reflects an exclusion that does not appear to be in compliance with Colorado insurance law. A policy may not exclude reimbursement for covered services performed by a licensed provider if the services are within the scope of the provider's license, and the provider normally charges for the services. In addition, a policy may not exclude reimbursement for covered benefits based solely upon the provider's status, e.g., a family member.

The wording on page 12 of the policy is:

SECTION 6 EXCEPTIONS

We will not pay benefits for:

(S) any services performed by a member of the covered person's immediate family;

Form Number	Form Name
A-3173CO	Major Medical Expense Policy

Recommendation No.4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to reflect that benefits may not be denied solely based on a provider's status (e.g. family member) as required by Colorado insurance law.

Issue E4: Failure to reflect correct information in a policy provision required for individual policies.

Section 10-16-202, C.R.S., Required provisions in individual sickness and accident policies, states:

> (1) Except as provided in section 10-16-204, each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this section in the words in which the same appear in this section; except that the insurer, at its option, may substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. …
>
> (8) A provision as follows: "Proofs of loss: Written proof of loss must be furnished to the insured at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable *and in case of claim for any other loss within ninety days after the date of such loss*. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, if such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, *later than one year from the time proof is otherwise required*." [Emphases Added.]

The required provision in the Company's most frequently sold policy in Colorado in 2002, concerning when "Proofs of loss" must be submitted in the absence of legal incapacity, appears to be more restrictive than allowed by Colorado insurance law. One year plus ninety (90) days is to be given to furnish such proof by virtue of the wording "from the time proof is otherwise required". The wording reflected in the policy only allows one year.

The following is reflected on page 12 of the policy:

SECTION 7	**HOW TO FILE A CLAIM**
PROOF OF YOUR CLAIM	You must give us written proof of all expenses you have incurred for which you are claiming benefits. This proof must reach us within 90 days after you have incurred the expense, or, if this is not possible, as soon as reasonably possible. Your proof must, however, be given us within 1 year, unless you are not legally competent to act.

Form Number	Form Name
A-3173CO	Major Medical Expense Policy

Recommendation No. 5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-202, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to ensure that the required provision concerning "Proofs of Loss" is in compliance with Colorado insurance law.

Issue E5: Failure to reflect required information in application and notice forms concerning replacement of accident and sickness coverage.

Regulation 4-2-1, (Repromulgated effective February 1, 2001) Replacement Of Accident And Sickness Insurance, promulgated under the authority of §§10-1-109 and 10-3-1110, Colorado Revised Statutes (C.R.S.) states:

Section 2. Purpose

The purpose of this regulation is to safeguard the interests of persons covered by individual accident and sickness insurance policies or plans who consider replacement of their coverage by making available to them information regarding replacement and thereby reducing the opportunity for misrepresentation and other unfair practices and methods of competition in the business of insurance.

Section 5. Rules

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has accident and sickness insurance in force or whether accident and sickness insurance is intended to replace or be in addition to any other accident and sickness insurance presently in force. A supplementary application or other form to be signed by the applicant and producer containing such questions and statements may be used.

[Statements]

(1) You normally do not require more than one policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid or Medicare and may not need an accident and sickness policy. If you are eligible for Medicare, you may want to purchase a Medicare Supplemental policy.

(4) If you are eligible for Medicare due to age or disability, counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program.

D. Upon determining that a sale will involve replacement of accident and sickness insurance, any issuer, other than a direct response issuer, or its producer, shall furnish the applicant, prior to issuance or delivery of the accident and sickness insurance policy or contract, a notice regarding replacement of accident and sickness insurance. One (1) copy of such notice signed by the applicant *and producer,* except where the coverage is old (sic) without a producer, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. [Emphasis added.] …

E. The Notice to Applicant Regarding Replacement of Accident and Sickness Insurance (Appendix A) required by Subsection D above for an issuer, shall be provided in the format prescribed and adopted by the Commissioner of Insurance.

F. Paragraphs 1 and 2, contained in such Notice to the Applicant Regarding Replacement of Accident and Sickness Insurance, (applicable to preexisting conditions), in Appendix A, may be deleted by the issuer if the replacement does not involve the application of a new preexisting condition limitation.

G. Failure to comply with the requirements of this Section 5 constitutes an unfair method of competition and an unfair or deceptive act or practice in the business of insurance which is prohibited under §10-3-1104, C.R.S.

Appendix A

NOTICE TO APPLICANT
REGARDING REPLACEMENT OF ACCIDENT
AND SICKNESS INSURANCE
(Insurance company's name and address)

According to (your application) (the information furnished by you), you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide [Number days of free look period, if any] days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER OR PRODUCER:

I have reviewed your current accident and sickness insurance coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s) (check one):

_____ Additional benefits

_____ No change in benefits but lower premiums

_____ Fewer benefits and lower premiums

_____ Other. (please specify)

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of claim for benefits under the new policy, whereas a similar claim may have been payable under your present policy.

2. State law provides that your replacement policy or contract may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The issuer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If, you wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. {If the policy or contract is guaranteed issued this paragraph need not appear].

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

The Company's application for insurance includes the required questions regarding replacement of other accident and sickness insurance, but it does not reflect the required statements, and there does not appear to be a supplementary application or other form used for this purpose. In addition, the form used by the Company as a Notice to Applicant Regarding Replacement of Accident and Sickness Insurance (Appendix A) does not appear to be complete or to be in the format prescribed and adopted by the Commissioner of Insurance.

Incomplete:

1) The Company's name and address is not reflected at the top of the notice or in the first paragraph of the form.

2) Although there is a signature line for the applicant there is no signature line or place for the typed name and address of the issuer or producer.

3) There is no "Statement To Applicant By Issuer Or Producer."

4) The following sentence is not reflected:
"Do not cancel your present policy until you have received your new policy and are sure that you want to keep it."

5) There is no second paragraph nor is the information contained therein reflected elsewhere in the form.

Non-compliant Format:

1) There is only one first paragraph of the Company's Form and it reads:

If you intend to lapse or terminate your present plan or you are age 65 or over and intend to purchase additional accident and health coverage, for your own information and protection, certain facts should be pointed out to you which should be considered before you make this change. Your new coverage provides 10 days after receipt of the policy within which you may decide without cost whether your desire to keep the plan. This free-look provision is extended to 20 days on Medicare Supplement and Long Term Care coverage.

2) Item 1 of the Company's Form reads:
Health conditions which you may presently have may not be covered under the new plan. This could result in a claim for benefits being denied which may be payable under your present coverage.

3) Item 2 of the Company's Form reads:
Even though some of your present health conditions may be covered under the new coverage, these conditions may be subject to certain waiting periods under the new plan before coverage is effective.

4) Item 3 of the Company's Form reads:
Questions in the application for the new plan must be answered truthfully and completely; otherwise, the validity of the coverage and the payment of any benefits thereunder may be voided.

Form Number	Form Name
A-3054-M	Application For Health Insurance
113 0454 CO	Notice To Applicant Regarding Replacement of, or Addition to, Accident and Sickness, Medicare Supplement, or Long Term Care Insurance

Recommendation No. 6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Repromulgated Regulation 4-2-1. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to include the required information regarding replacement of coverage to ensure compliance with Colorado insurance law.

Issue E6: Failure to reflect a correct definition of a Business Group of One in an Applicant Disclosure form.

Section 10-16-102, C.R.S., Definitions, states:

> (6) (a) "Business group of one" means, for purposes of qualification, an individual, a sole proprietor, or a single full-time employee of a subchapter S corporation, C corporation, nonprofit corporation, limited liability company, or partnership who works twenty-four hours or more a week on a permanent basis and who has carried on significant business activity for a period of at least one year prior to application for coverage, has *gross income* as indicated on federal internal revenue service forms 1040, schedule C, F, or SE, or other forms recognized by the federal internal revenue service for income reporting purposes which generated *gross income* from which that individual, sole proprietor, or single full-time employee has derived at least a substantial part of such individual's income for one year out of the most recent *consecutive three-year period*. [Emphases added.] For the purposes of this subsection (6), "substantial part of such individual's income" means income derived from business activities of the business group of one that are sufficient to pay for annual health insurance premiums for the business group of one.

The Company's definition of a Business Group of One, as reflected in an Applicant Disclosure form, does not appear to correctly reflect Colorado insurance law in the following ways:

1. The word "taxable income" has been substituted for the required "gross income" in the two places it appears in the definition.

2. The wording in the definition is incorrect in that it states, "which generated taxable income in one of the two previous years" and " for one year out of any consecutive three-year period" instead of the required wording of, " for one year out of the most recent consecutive three-year period".

The wording in the Applicant Disclosure form is:

COLORADO BUSINESS GROUPS of ONE

Colorado law defines a Business Group of One as an individual, a sole proprietor, or a single full-time employee of a subchapter S corporation, C corporation, nonprofit corporation, limited liability company, or partnership who works 24 hours or more a week on a permanent basis and who has carried on significant business activity for a period of at least one year prior to the application for coverage, has taxable income as indicated on Federal Internal Revenue Service forms 1040, Schedule C, F, or SE, or other forms recognized by the Federal Internal Revenue Service for income reporting purposes which generated taxable income in one of the two previous years or from which that individual, sole proprietor, or single full-time employee has derived at least a substantial part of such individual's income for one year out of any consecutive three-year period. ...

Form Number	Form Name
F-1015	Applicant Disclosure

Recommendation No. 7:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-102, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect a definition of a Business Group of One that is in compliance with Colorado insurance law.

Issue E7: Failure to reflect correct or complete information in the CoverColorado Notice Form.

Amended Regulation 4-6-3, Concerning CoverColorado Standardized Notice Form And Eligibility Requirements, promulgated by the Commissioner of Insurance under the authority of §§ 10-1-109 and 10-8-520, C.R.S., states:

> Section 4. Rules
>
> C. Elements of the CoverColorado Notice Form for Adverse Underwriting Decisions
>
> The elements of notification as determined by the Commissioner, which must be given to individuals with adverse underwriting decisions are:
>
> Applicant/Insured's:
>
> 1. Name.
> 2. Policy number (if applicable).
> 3. Reasons for notice: rejection of coverage, health rate higher than the rate available through CoverColorado or coverage that will be reduced by a restrictive rider or by excluding coverage for a pre-existing condition longer than six months or involuntarily terminated for reasons other than nonpayment of premium.
> 4. That the individual and dependents are eligible for the health care coverage through CoverColorado.
> 5. Name, address, contact person, and telephone number of CoverColorado Administrative Office to whom interested persons should be referred.
> 6. Name and phone number of underwriter or other contact at the carrier's office.
> 7. A statement that the applicant may receive information about the available CoverColorado benefits and exclusions by contacting the CoverColorado Administrative Office.

Bulletin No. 13-01, Concerning CoverColorado Standardized Notice Form For Health Insurers, states:

> III. Effective January 1, 2002, all carriers authorized to conduct business in Colorado and offer health benefit plans are to provide the attached CoverColorado Notice Form to individuals who are eligible for coverage under the Colorado Uninsurable Health Insurance Plan as prescribed under 10-8-513, C.R.S.

This form is attached to this Bulletin as Exhibit A. Reproduction by insurers is authorized. Insurers may print the CoverColorado Plan Notice form on their own stationary but *should use the order, format and content as specified*. [Emphasis added.]

EXHIBIT A

COVERCOLORADO PLAN NOTICE FORM

Issued: December 7, 2001
For more information regarding CoverColorado, please contact:

CoverColorado
1700 Broadway, Ste 430
Denver, CO 80290
303-863-1960

Reissued: April 1, 2002
For more information regarding CoverColorado, please contact:

CoverColorado
425 S. Cherry Street # 160
Glendale, CO 80246
303-863-1960

The Company's CoverColorado Standardized Notice Form For Health Insurers did not appear to reflect correct or complete content, prior to July 2002, in the following ways:

Incorrect: The address and telephone number reflected in the Company's form for obtaining information about the CoverColorado program is:

Cover Colorado
P.O. Box 33760
Indianapolis, IN 46203-8447
1-800-672-8447

Incomplete: The following reasons requiring the CoverColorado Notice Form are not reflected:

i. You had a health plan involuntarily terminated by a carrier in this state for any reason other than nonpayment of premium and is effective within the sixty-two (62) days after termination of such individual's prior coverage; or

ii. You meet the definition of a federally eligible individual under Colorado Revised Statute 10-16-105.5, and are not subject to the eligibility requirements of Colorado Revised Statute 10-8-513. A dependent of a federally eligible individual shall be eligible for coverage under CoverColorado if the dependent satisfies the definition of "dependent" under Colorado Revised Statute 10-16-102(14). A federally eligible individual means an individual:

1. Who has of the date on which the individual seeks coverage, the aggregate of periods of creditable coverage is eighteen months or more and the most recent prior creditable coverage was under a group health plan. As used in definition, "group health plan" means an employee welfare benefit plan as defined in 29 U.S.C., Sec. 1002(1) of the federal "Employee Retirement Income Security Act of 1974" to the extent that the plan provides health care services, including items and services paid for as health care services, to employees or their dependents directly or through insurance reimbursement or otherwise. A "Group Health plan" includes a government or church plan.

2. Who is not eligible for coverage under a group health benefit plan, Medicare, or Medicaid and does not have other health benefit plan coverage;

3. Whose most recent coverage was not terminated as a result of nonpayment of premium or fraud; and

4. Who did not turn down an offer of continuation coverage if it was offered and who subsequently exhausted such coverage.

Form Number	Form Name
018310298/09671	CoverColorado Notice Form

Recommendation No. 8:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-3. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its CoverColorado Standardized Notice Form to reflect correct and complete elements of notification as required by Colorado insurance law.

Issue E8: Failure to reflect correct and complete coverage to be provided for home health care services.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(7) Reimbursement of providers.

(a) Sickness and accident insurance

(I)(A) Notwithstanding any provisions of any policy of sickness and accident insurance issued by an entity subject to the provisions of part 2 of this article or a prepaid dental care plan subject to the provisions of part 5 of this article, whenever any such policy or plan provides for reimbursement for any service that may be lawfully performed by a person licensed in this state for the practice of osteopathy, medicine, dentistry, dental hygiene, optometry, psychology, chiropractic, or podiatry, reimbursement under such policy or plan shall not be denied when such service is rendered by a person so licensed. Nothing in this part 1 or parts 2 or 5 of this article shall preclude an insurance company from setting different fee schedules in an insurance policy for different services performed by different professions, but the same fee schedule shall be used for those portions of health services that are substantially identical although performed by different professions.

(B) The licensed persons who may not be denied reimbursement pursuant to sub-paragraph (A) of this subparagraph (I) shall include registered professional nurses and licensed clinical social workers. However, such inclusion shall not be interpreted as enlarging the scope of professional nursing or licensed clinical social worker practice. For purposes of this subsection (7), "licensed clinical social worker" shall have the meaning set forth in subparagraph (III) of paragraph (b) of subsection (5) of this section.

(II) The provisions of subparagraph (I) of this paragraph (a) shall apply:

(A) To all individual sickness and accident policies issued on and after July 1, 1973;

Amended Regulation 4-2-8, Concerning Required Health Insurance Benefits For Home Health Services And Hospice Care promulgated under the authority of Sections 10-1-109 and 10-16-104(8)(d), Colorado Revised Statutes (C.R.S.) states:

Section 4. Requirements for Home Health Services

C. Benefits for Home Health Care Services.

(2) The policy or certificate may contain a limitation on the number of home health visits, but no policy offered may provide for fewer than *60 home health visits* in any calendar year. [Emphasis added.]

Section 5. Requirements for Hospice Care

A. Definitions

(4) A "patient/family" is one unit of care consisting of those individuals who are closely linked with the patient, including the immediate family, the *primary care giver and individuals with significant personal ties.* [Emphasis added.]

The Company's Endorsement for Home Health Care Benefit form does not completely or correctly describe the mandated home health care benefits. The endorsement only has a definition of an Immediate Family which consists of an insured person's spouse, children, parents, grandparents, brothers, and sisters of a covered person and their spouse. A "patient/family", (one unit of care) for bereavement benefit purposes as defined in Colorado insurance law, considers in addition to the immediate family, the primary care giver and individuals with significant personal ties. In addition, the endorsement reflects an exclusion that does not appear to be in compliance with Colorado insurance law as it is unlawful to deny reimbursement for covered benefits when lawfully performed by a licensed provider who is also a family member or resides in the covered person's home.

The Home Health Care Benefits reflected in the most frequently sold policy in Colorado in 2002 do not appear to be in compliance with Colorado insurance law in that the plan limits the visits to forty (40) instead of not fewer than sixty (60) in any calendar year and also reflects that the services must be performed by someone other than a member of the covered person's immediate family. Additionally, the definition of Home Health Care Expenses in the policy reflects an exclusion that appears to be too broad as it indicates that expenses do not cover services of an otherwise eligible provider who happens to also be a family member or lives in the patient's household.

The wording on the Endorsement for Home Health Care Benefits is:

BENEFITS

Immediate family means the spouse, children, parents, grandparents, brothers, and sisters of a covered person and their spouse.

EXCEPTIONS

(5) Services given by a person who resides in the covered person's home, or is a member of the covered person's immediate family;

The wording on page 3 of the policy is:

SECTION 1 BENEFITS

(F) Home health care or nursing service visits. We will pay for up to one visit per day for up to *40 visits* during a policy year. Such visits must be provided by a home health care agency, a nurse or a licensed home health aide/homemaker as a part of a plan of treatment prescribed by the attending doctor. The doctor must certify that without the home health care or nursing visits, the covered person would have required a stay in a hospital or skilled nursing facility. The home health care or nursing service must be performed by someone *other than a member of the covered person's immediate family.* The covered person must be under the care of a doctor. [Emphasis added.]

The wording on page 7 of the policy is:

SECTION 2 DEFINITIONS

HOME HEALTH CARE EXPENSES do not include: services or supplies not included in the home health care plan; or *services of a person who ordinarily resides in the home of the covered person; or services performed by a member of the covered person's immediate family;* or custodial care or transportation services; or charges for any period during which the insured is not under the continuing care of a doctor; or home health care to the extent such charges are covered by the policy to which this agreement is part. [Emphasis added.]

Form Number	Form Name
A-2307CO 2-94	Endorsement Home Health Care Benefit
A-3173CO	Major Medical Expense Policy

Recommendation No. 9:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S., and Amended Regulation 4-2-8. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its policy forms and endorsements to correctly and completely describe the coverage to be provided for home health care services as required by Colorado insurance law.

Issue E9: Failure to reflect correctly and completely the extent of coverage to be provided for hospice care services.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(7) Reimbursement of providers.

(a) Sickness and accident insurance.

(I)(A) Notwithstanding any provisions of any policy of sickness and accident insurance issued by an entity subject to the provisions of part 2 of this article or a prepaid dental care plan subject to the provisions of part 5 of this article, whenever any such policy or plan provides for reimbursement for any service that may be lawfully performed by a person licensed in this state for the practice of osteopathy, medicine, dentistry, dental hygiene, optometry, psychology, chiropractic, or podiatry, reimbursement under such policy or plan shall not be denied when such service is rendered by a person so licensed. …

(II) The provisions of subparagraph (I) of this paragraph (a) shall apply:

(A) To all individual sickness and accident policies issued on and after July 1, 1973.

(8) Availability of hospice care coverage.

(d) The commissioner, in consultation with the department of public health and environment, may establish by rule and regulation requirements for standard policy and plan provisions which state clearly and completely the criteria for and extent of insured coverage for home health services and hospice care. Such provisions shall be designed to facilitate prompt and informed decisions regarding patient placement and discharge.

Amended Regulation 4-2-8, Concerning Required Health Insurance Benefits For Home Health Services And Hospice Care, promulgated under the authority of Sections 10-1-109 and 10-16-104(8)(d), C.R.S., states:

Section 2. Purpose

The purpose of this regulation is to establish requirements for standard policy provisions, which state *clearly and completely the criteria for and extent of coverage for home health services and hospice care* and to facilitate prompt and informed decisions regarding patient placement and discharge. [Emphasis added.]

Section 5. Requirements for Hospice Care

A. Definitions.

(4) *A "patient/family" is one unit of care consisting of those individuals who are closely linked with the patient, including the immediate family, the primary care giver and individuals with significant personal ties*. [Emphasis added.]

(12) *"Home care services" are hospice services, which are provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility*. [Emphasis added.]

(18) A "benefit period" for hospice care services is a period of three months, during which services are provided on a regular basis.

(19) A "hospice per diem" rate is the predetermined rate for each day in which an individual is enrolled in a hospice program and under its care, without regard to which, if any, services are actually provided on a specific day.

B. General Provisions Pertaining to Hospice Care

(2) The policy offering shall provide that benefits are allowed only for individuals who are terminally ill and have a life expectancy of six months or less, except that benefits may exceed six months should the patient continue to live beyond the prognosis for life expectancy, in which case the benefits shall continue at the same rate for one additional benefit period. *After the exhaustion of three benefit periods, the insurer's case management staff shall work with the individual's attending physician and the hospice's Medical Director to determine the appropriateness of continuing hospice care*. [Emphasis added.]

C. Benefits for Hospice Care Services

(2) The policy or certificate may contain a dollar limitation on routine home care hospice benefits. Other services provided by or through the hospice that are available to the insured will be negotiated at a hospice per diem rate with the hospice provider. *Any policy offered shall provide a benefit of no less than $100 per day* for any combination of the following routine home care services, which are planned, implemented and evaluated by the interdisciplinary team:

The total benefit for each benefit period for these services shall not be less than the per diem benefit multiplied by ninety-one (91) days. [Emphasis added.]

(3) *The policy offering shall include the following benefits, subject to the policy's deductible, coinsurance and stoploss provisions, which are exclusive of and shall not be included in the dollar limitation for hospice care benefits as specified in (2) above*: [Emphasis added.]

(a) Bereavement support services for the family of the deceased person during the *twelve month period following death, and in no event shall this maximum benefit be less than $1150*. [Emphasis added.]

(b) Short-term general inpatient (acute) hospice care or continuous home care which may be required during a period of crisis, for pain control or symptom management and shall be paid consistent with any other sickness or illness (i.e., not included in the per diem limitation specified in (2) above). Such care shall require prior authorization of the interdisciplinary team and may, except for emergencies, weekends or holidays, require prior authorization by the insurer, provided, however, that the insurer may not require prior authorization when the transfer to the higher level of care was necessary during the insurer's non-business hours if the hospice seeks the authorization during the insurer's first business day;

(c) Medical supplies;

(d) Drugs and biologicals;

(e) Prosthesis and orthopedic appliances;

(f) Oxygen and respiratory supplies;

(g) Diagnostic testing;

(h) Rental or purchase of durable equipment;

(i) Transportation;

(j) Physicians services;

(k) Therapies including physical, occupational and speech; and Nutritional counseling by a nutritionist or dietitian.

(1) The Hospice Care Services Benefit Endorsement used by the Company reflects an exclusion that does not appear to be in compliance with Colorado insurance law as it is unlawful to deny reimbursement for covered home health care services to licensed providers based upon the provider's status, e.g., residing in the home or being a member of the covered person's immediate family.

The wording on page 3 and page 4 of the endorsement is:

EXCLUSIONS AND LIMITATIONS …
This Hospice Care Services benefit will not pay for:

(4) Services given by a person who resides in the covered person's home, or is a member of the covered person's immediate family;

(2) An incorrect maximum hospice per diem rate of $91.00 is reflected. The correct maximum hospice per diem rate as of February 1, 2001 was $100.

(3) An incorrect maximum amount of $8,100 for a three (3) month period is reflected. The total benefit for each benefit period for hospice care services shall not be less than the per diem benefit multiplied by ninety-one (91) days, which is $9,100.

(4) An incorrect statement appears to be reflected with reference to hospice care benefits being automatically limited to a maximum of nine (9) months. Colorado insurance law requires that after the exhaustion of three (3) benefit periods the insurer's case management staff shall work with the individual's attending physician and the hospice's Medical Director to determine the appropriateness of continuing hospice care.

The wording on page 1 of the endorsement is:

> We will pay benefits for:
>
> (A) Covered Home Hospice Care Expenses. We will pay up to a maximum of $8,100.00 for a 3 month period, payable at a rate of up to $91.00per day for any combination of such Covered Home Hospice Care Expenses. This benefit is limited to a maximum of 9 months.
>
> (D) Medical supplies, including drugs and biologicals. We will pay for up to 9 months.
>
> (E) Prosthesis and orthopedic appliances. We will pay benefits for such expenses incurred for up to 9 months.

(5) An incorrect maximum bereavement support service amount of $1,077 and an incorrect period of time for the services to be provided of three (3) months is reflected. As of February 1, 2001 the correct maximum benefit for this service was $1,150 and the correct period of time for the service to be provided was twelve (12) months following death.

(6) The definition of "Immediate Family" that is reflected and the explanation of who may receive bereavement support services appears to be more limiting than allowed by Colorado insurance law. A patient/family is to be one unit of care consisting not only of the immediate family, but also the primary care giver and individuals with significant personal ties.

The wording on page 1 of the endorsement is:

> We will pay benefits for:
>
> (B) Bereavement Support Services. We will pay up to a maximum of $1077.00 for the immediate family of the deceased covered person. We will pay such benefit during the 3 month period following the terminally ill covered person's death.

The wording on page 2 of the endorsement is:

> BEREAVEMENT SUPPORT SERVICES means counseling services provided to members of a deceased covered person's immediate family to aid them in adjusting to the covered person's death.
>
> IMMEDIATE FAMILY means spouse, children, parents, grandparents, brothers, and sisters of a covered person and their spouse.

(7) An incorrect maximum benefit period of thirty (30) days of care is reflected for short-term inpatient hospice or continuous home care which may be required during a period of crisis, for pain control or for acute intervention alternatives and chronic symptom management. This limitation was eliminated as of February 1, 2001 with a requirement that the benefits are to be paid consistent with any other sickness or illness, (i.e., not included in the per diem limitation). The description of this benefit also appears to be incomplete in the two (2) following ways:

1. There is nothing reflected concerning the two (2) exceptions (weekends and holidays) for obtaining advance authorization for short-term general inpatient (acute) hospice care or continuous home care during a period of crisis, for pain control or symptom management.

2. There is nothing reflected to indicate that prior authorization may not be required if transfer to the higher level of care was necessary during the insurer's non-business hours if the hospice seeks the authorization during the insurer's first business day.

The wording on page 1 of the endorsement is:

> We will pay benefits for:
>
> (C) Short-term inpatient hospice care or continuous home care. We will pay up to 30 days of short-term inpatient hospice or continuous home care which may be required during a period of crisis, for pain control or for acute intervention alternatives and chronic symptom management. Such care must be authorized by the interdisciplinary team. We may require prior approval of such care, except in the case of an emergency.

(8) There is nothing reflected to indicate that there are twelve (12) benefits which are subject to the deductible, coinsurance and stoploss provisions, but are exclusive of and not to be included in the dollar limitation for hospice care per diem benefits.

(9) There is nothing reflected in the plan concerning the fact that "Home care services" are hospice services, to be provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility.

Form Number	Form Name
A-2562CO 2-94	Hospice Care Services Benefit Endorsement

Recommendation No. 10:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. and Amended Regulation 4-2-8. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised any applicable forms and endorsements to reflect correctly and completely the extent of coverage required to be provided for hospice care coverage as required by Colorado insurance law.

Issue E10: Failure to disclose the mandated hospitalization and general anesthesia benefit for dental procedures for dependent children.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(12) Hospitalization and general anesthesia for dental procedures for dependent children.

(a) All individual and all group sickness and accident insurance policies that are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article except supplemental policies that cover a specific disease or other limited benefit shall provide coverages for general anesthesia, when rendered in a hospital, outpatient surgical facility, or other facility licensed pursuant to section 25-3-101, C.R.S., and for associated hospital or facility charges for dental care provided to a dependent child, as dependent is defined in section 10-16-102 (14), of a covered person. Such dependent child shall, in the treating dentist's opinion, satisfy one or more of the following criteria:

(I) The child has a physical, mental, or medically compromising condition; or
(II) The child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or
(III) The child is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred; or
(IV) The child has sustained extensive orofacial and dental trauma.

A review of the Company's most frequently sold plan in Colorado in 2002 revealed no indication of notification to the insured concerning the mandated coverage of hospitalization and general anesthesia for dental procedures for dependent children when certain criteria are met. Additionally there is a specific exception in the policy for dental care, surgery or treatment except for reconstructive surgery when such service is incidental to an injury.

The exception wording on page 11 of the policy is:

SECTION 6 EXCEPTIONS

We will not pay benefits for:

(H) dental care, surgery or treatment. We will pay for reconstructive surgery when such service is incidental to an injury which occurred while this policy is in force;

Form Number	Form Name
A-3173CO	Major Medical Expense Policy

Recommendation No. 11:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its policy forms to disclose to insureds, as required by Colorado insurance law, the mandated hospitalization and general anesthesia benefit for dental procedures for dependent children when certain criteria is met.

Issue E11: Failure to reflect that repairs and replacement of prosthetic devices, unless due to misuse or loss, are to be covered.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(14) Prosthetic devices

(b) For the purposes of this subsection (14) "prosthetic device" means an artificial device to replace, in whole or in part, an arm or leg.
(e) Repairs and replacements of prosthetic devices are also covered, subject to copayments and deductibles, unless necessitated by misuse or loss.

The Company's most frequently sold plan in Colorado in 2002 does not appear to reflect the mandatory coverage of repair and replacement of prosthetic devices, subject to copayments and deductibles, unless necessitated by misuse or loss.

The wording on page 4 of the policy describing this benefit is:

SECTION 1 BENEFITS

The benefits of this policy for a covered person are paid as set out below:

(P) Permanent basic artificial limbs, eyes, casts, splints, trusses, braces or crutches.

Form Number	Form Name
A-3173CO	Major Medical Expense Policy

Recommendation No. 12:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its policy forms to reflect, as required by Colorado insurance law, that repairs and replacements of prosthetic devices are to be covered unless necessitated by misuse or loss.

Issue E12: Failure to reflect complete mandated preventive child health supervision service benefits.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(11) Child health supervision services.

(a) For purposes of this subsection (11), unless the context otherwise requires, *"child health supervision services" means those preventive services and immunizations required to be provided in basic and standard health benefit plans pursuant to section 10-16-105 (7.2)*, to dependent children up to age thirteen. [Emphasis added.] Such services shall be provided by a physician or pursuant to a physician's supervision or by a primary health care provider who is a physician's assistant or registered nurse who has additional training in child health assessment and who is working in collaboration with a physician.

(b) An individual, small group, or large group health benefit plan issued in Colorado or covering a Colorado resident that provides coverage for a family member of the insured or subscriber, shall, as to such family member's coverage, also provide that the health insurance benefits applicable to children include coverage for child health supervision services up to the age of thirteen. …

Amended Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

Attachment 1

COVERED PREVENTIVE SERVICES	
All Children	Immunization deficient children are not bound by "recommended ages" on immunization chart
Age 0-12 months	1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery.
	1 PKU

The Company uses an Endorsement to reflect the Child Health Supervision Service Benefits provided by the most frequently sold plan in Colorado in 2002. The benefits reflected do not appear to be in compliance with the requirements of Colorado insurance law in that the following coverages, and information concerning coverage, are not reflected:

1. 1 newborn home visit during the first week of life if the newborn is released from the hospital less than 48 hours after delivery.
2. 1 PKU during age 0-12 months.
3. Immunization deficient children are not bound by "recommended ages" on the current recommendations for routine immunization of infants and children in the United States.

The wording on the one page endorsement is:

CHILD HEALTH SUPERVISION SERVICES BENEFITS

We will pay benefits for eligible child health supervision services as defined below for a covered child. The eligible child health supervision services benefits are limited to those set out in this Endorsement, and shall only be covered to the extent such services are provided during the course of one visit by or under the supervision of one doctor. We will pay for eligible child health supervision services up to:

(1) five well-child visits from birth to 12 months of age;

DEFINITIONS
CHILD HEALTH SUPERVISION SEVICES means preventive services, appropriate immunizations, developmental assessments and laboratory services appropriate to the age of the child from birth to age 13, based on the recommendations of the American Academy of Pediatrics and the laws of your State.

Form Number	Form Name
A-2803CO	ENDORSEMENT CHILD HEALTH SUPERVISION SERVICES BENEFITS

Recommendation No. 13:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. and Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its Child Health Supervision Services Benefits endorsement to reflect complete mandated coverages and information concerning coverages as required by Colorado insurance law.

Issue E13: Failure to reflect an accurate or complete description of the mandated therapies for congenital defects and birth abnormalities for children.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(1.7) Therapies for congenital defects and birth abnormalities.

(a) After the first thirty-one days of life, policy limitations and exclusions that are generally applicable under the policy may apply; except that all individual and group health benefit plans shall provide medically necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children up to five years of age.

(b) The level of benefits required in paragraph (a) of this subsection (1.7) shall be the greater of the number of such visits provided under the policy or plan or twenty therapy visits per year each for physical therapy, occupational therapy, and speech therapy. Said therapy visits shall be distributed as medically appropriate throughout the yearly term of the policy or yearly term of the enrollee coverage contract, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.

The Company's most frequently sold plan in Colorado in 2002 does not appear to reflect a complete or an accurate description of the mandated therapies for congenital defects and birth abnormalities for children in the following ways:

Incomplete

1. Although the policy states, under coverage for "Newborn Children" that coverage includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, there is no mention that physical, occupational and speech therapy are to be provided for covered children's care and treatment up to five years of age.

2. There is nothing reflected to indicate that the minimum level of benefits to be provided for congenital defects and birth abnormalities for children is twenty visits per year for each type of therapy or if greater, the number of such visits provided under the plan.

Incorrect

1. This therapy is to be provided without regard as to whether the purpose is to maintain or improve functional capacity. The Preferred Provider Endorsement used by the Company to amend Item "O", (physical or speech therapy), in the list of policy Eligible Expenses indicates there will be no payment for physical, speech or occupational therapy if rendered for maintenance only and/or there is no measurable progressive achievement of established goals.

2. Colorado insurance law requires that the minimum level of benefits required to be available is twenty (20) visits per year for each of three types of therapy which correlates to a total of

sixty (60) visits. The Preferred Provider Endorsement amending Item "O" (physical or speech therapy) of the policy reflects that services from a nonparticipating provider are limited to 10 outpatient visits per policy year and one visit consists of up to 3 hours of therapy within a 24 hour period.

The wording on page 10 of the policy is:

SECTION 5	**COVERED PERSONS**
Newborn Child	Your newborn child will be covered by this policy for injury and sickness from the moment of birth for 31 days. This includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, but not routine nursery or well baby care. Your child may then be covered for life. However, you must apply to add the child within 31 days after the child's birth. There will be an added premium for your child's coverage. To keep your child insured, you must send us the premium within 31 days after we send you a notice for the added premium.

The wording on page 1 of the Preferred Provider Endorsement is:

Item (O) in the list of Eligible Expenses is amended to read as follows:

Physical medicine in or out of the hospital. Physical medicine includes, but is not limited to physical, speech or occupational therapy, sports medicine, pulmonary or cardiac rehabilitation therapy. Services from a nonparticipating provider will be limited to 10 outpatient visits per policy year. One visit consists of up to 3 hours of therapy within a 24 hour period. The therapy must be part of a treatment plan approved by the attending doctor. We will not pay for such services if they are rendered for maintenance only and/or there is no measurable, progressive achievement of established goals.

Form Number	Form Name
A-3173CO	Major Medical Expense Policy
A-3562CO	Preferred Provider Endorsement

Recommendation No. 14:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its policies and endorsements to reflect an accurate and complete description of the mandated therapies for congenital defects and birth abnormalities for children as required by Colorado insurance law.

Issue E14: Failure to provide coverage for routine hospital nursery care for newborns.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(1) Newborn children.

(a) All group and individual sickness and accident insurance policies and all service or indemnity contracts issued by any entity subject to part 3 or 4 of this article shall provide coverage for a dependent newborn child of the insured or subscriber from the moment of birth.

(b)(I) Coverage for a hospital stay for a newborn following a normal vaginal delivery shall not be limited to less than forty-eight hours. If forty-eight hours following delivery falls after 8 p.m., coverage shall continue until 8 a.m. the following morning.

(II) Coverage for a hospital stay for a newborn following a cesarean section shall not be limited to less than ninety-six hours. If ninety-six hours following the cesarean section falls after 8 p.m., coverage shall continue until 8 a.m. the following morning.

The Company's exclusion for routine nursery charges for newborns in its most frequently sold policy in Colorado in 2002 does not appear to be in compliance with the requirements of Colorado insurance law which requires coverage for a hospital stay for a newborn for at least forty-eight (48) or ninety-six (96) hours depending on the type of delivery.

The wording on page 10 of the policy is as follows:

NEWBORN CHILD

Your newborn child will be covered by this policy for injury and sickness from the moment of birth for 31 days. This includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, but not routine nursery or well baby care. Your child may then be covered for life. However, you must apply to add the child within 31 days after the child's birth. There will be an added premium for your child's coverage. To keep your child insured, you must send us the premium within 31 days after we send you a notice for the added premium.

Form Number	Form Name
A-3173CO	Major Medical Expense Policy

Recommendation No. 15:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its policies to reflect the required hospital stay coverage for newborns as required by Colorado insurance law.

Issue E15: Failure to reflect an accurate description of the mandated coverage for prostate cancer screening.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(10) Prostate cancer screening.

(a) All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, which are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage offered to residents of this state, shall provide coverage for annual screening for the early detection of prostate cancer in men over the age of fifty years and in men over the age of forty years who are in high-risk categories, which coverage by entities subject to part 2 or 3 of this article shall not be subject to policy deductibles. Such coverage shall be the lesser of sixty-five dollars per prostate cancer screening or the actual charge for such screening. *Such benefit shall in no way diminish or limit diagnostic benefits otherwise allowable under a policy*. [Emphasis added.] This coverage shall be provided according to the following guidelines:

A correct description of the mandatory coverage of prostate cancer screening is reflected in the benefit section of the Company's most frequently sold policy in Colorado in 2002. However, the policy also includes a wellness endorsement that indicates it amends the BENEFITS Section of the policy by including prostate cancer screenings under the wellness benefits. The endorsement reflects a six (6) month waiting period for wellness benefits and a policy year maximum amount to be paid for policy year 1 through policy year 3+. This appears to be in conflict with Colorado insurance law and contradicts the description of prostate cancer screening in the policy. Additionally, the wellness endorsement lumps this benefit in with other services subject to maximum annual amounts which does not appear to correspond to the statutory requirement that this benefit shall not diminish or limit diagnostic benefits otherwise allowable under a policy.

The wording on page 2b of the policy is:

WELLNESS ENDORSEMENT:

	Preferred Provider	**Nonparticipating Provider**
Wellness Waiting Period:	6 months	6 months
Wellness Service Policy Year Maximum Amount:	Policy Year 1	$100.00
(total, per covered person, preferred providers and	Policy Year 2	$200.00
nonparticipating providers)	Policy Year 3+	$300.00

The wording on page 1 of the Wellness Endorsement is:

The provisions of this Endorsement will become effective after the applicable Wellness Waiting Period shown on the Policy Data Page has been satisfied.

WELLNESS SERVICES

WELLNESS SERVICE POLICY YEAR MAXIMUM… During each policy year, benefits under this Endorsement will be payable up to the Wellness Service Policy Year Maximum Amount per covered person, as shown on the Policy Data Page. The eligible expenses incurred may be for either preferred provider or nonparticipating provider wellness services.

WELLNESS EXPENSES …The following are considered eligible wellness services under this Endorsement:

(B) preventative screening procedures including, but not limited to, …prostate cancer screenings …

Form Number	Form Name
A-3566CO	Wellness Endorsement

Recommendation No. 16:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its policy forms to reflect an accurate and non-contradictory description of the mandatory coverage to be provided for prostate cancer screenings as required by Colorado insurance law.

Issue E16: Failure to reflect correct benefits for mammography screening.

Section 10-16-104(4), C.R.S., Mandatory coverage provisions, states:

(4) Low-dose mammography.

(a) For the purposes of this subsection (4), "low-dose mammography" means the X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, and film and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast. All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, which are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage provided to residents of this state, shall provide coverage *for routine and certain diagnostic* screening by low-dose mammography for the presence of breast cancer in adult women. *Routine and diagnostic* screenings provided pursuant to subparagraph (II) or (III) of this paragraph (a) shall be provided on a contract year or a calendar year basis by entities subject to part 2 or 3 of this article and *shall not be subject to policy deductibles*. Such coverages shall be the lesser of sixty dollars per mammography screening, or the actual charge for such screening. *The minimum benefit required under this subsection (4) shall be adjusted to reflect increases and decreases in the consumer price index*. Benefits for routine mammography screenings shall be determined on a calendar year or a contract year basis, which shall be specified in the policy or contract. The routine and diagnostic coverages provided pursuant to this subsection (4) *shall in no way diminish or limit diagnostic benefits otherwise allowable under a policy*. … [Emphases added.] This mandated mammography coverage shall be provided according to the following guidelines:

(I) Provision of a single baseline mammogram for women thirty-five years of age and under forty years of age;
(II) Screening not less than once every two calendar years or contract years for women forty years of age and under fifty years of age, as specified in the insured's policy or contract, but at least once each such calendar year or contract year for a woman with risk factors to breast cancer as determined by her physician for an entity subject to part 2 or 3 of this article, or as determined by a participating physician for an entity subject to part 4 of this article;
(III) Annual screening, on a calendar year or contract year basis, for women who are fifty to sixty-five years of age.

(b) The requirements of this section shall apply to all individual sickness and accident insurance policies and health care service or indemnity contracts issued on or after July 1, 1995, …

The Company's most frequently sold policy in Colorado in 2002 does not appear to reflect correct or complete information concerning the mandated coverage to be provided for mammography in the following ways:

Incorrect

(1) Mammograms are reflected as a wellness service in the Wellness Endorsement and the policy indicates there is a wellness waiting period of six (6) months. Colorado insurance law does not require coverage to have been in effect for six (6) months before this mandated benefit is to be provided.

(2) The policy reflects that the Wellness Endorsement has a policy year maximum amount per covered person for Policy Year 1 through Policy Year 3+. Lumping mammogram benefits in with other services subject to a maximum annual amount does not correspond to the statutory requirement that this benefit shall not diminish or limit diagnostic benefits otherwise allowable under a policy.

(3) An Endorsement amending the policy eligible expenses, exceptions and general provisions section, inserts the word "routine" as the only descriptive word for the mammography benefit. The required coverage for mammograms in Colorado insurance law includes diagnostic screenings as well as routine screenings.

Incomplete

(1) There is nothing reflected concerning the minimum benefit amount for mammograms or the fact that this amount is to be adjusted to reflect increases and decreases in the consumer price index.

(2) Nothing is reflected concerning the guideline age categories for a baseline mammogram, semiannual and annual screenings, or screenings for women with risk factors to breast cancer.

The wording on page 1 of the Wellness Endorsement is:

> **The provisions of this Endorsement will become effective after the applicable Wellness Waiting Period shown on the Policy Data Page has been satisfied.**
>
> The policy to which this Endorsement is attached is amended by adding the following provision to the BENEFITS Section:
>
> WELLNESS SERVICE POLICY YEAR MAXIMUM… During each policy year, benefits under this Endorsement will be payable up to the Wellness Service Policy Year Maximum Amount per covered person, as shown on the Policy Data Page. The eligible expenses incurred may be for either preferred provider or nonparticipating provider wellness services.
>
> **WELLNESS EXPENSES …**The following are considered eligible wellness services under this Endorsement:
>
> (B) preventative screening procedures including, but not limited to, mammography …

The wording on page 2b of the policy is:

WELLNESS ENDORSEMENT:

	Preferred Provider	**Nonparticipating Provider**
Wellness Waiting Period:	6 months	6 months

Wellness Service Policy Year Maximum Amount: (total, per covered person, preferred providers and nonparticipating providers)	Policy Year 1	$100.00
	Policy Year 2	$200.00
	Policy Year 3+	$300.00

The wording on page 1 of the amending endorsement is:

The policy to which this Endorsement is attached is amended as follows:

Item (I) in the list of Eligible Expenses is amended to read as follows:

X-rays and radiology in or out of the hospital. This includes routine mammograms when performed by or at the direction of a doctor.

Item (I), prior to being amended, on page 4 of the policy reflects:

(I) X-rays and radiology in or out of the hospital. This includes mammograms when performed by or at the direction of a doctor.

Form Number	Form Name
A-3173CO	Major Medical Expense Policy
A-3566CO	Wellness Endorsement
A-3563CO	Endorsement amending eligible expenses, exceptions and general provisions

Recommendation No. 17:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its policy forms and amending endorsements to reflect correct and complete benefits to be provided for the mandated coverage of mammography screenings as required by Colorado insurance law.

UNDERWRITING
RATING
FINDINGS

Issue F1: Failure, in some instances, to use the rates filed with the Colorado Division of Insurance.

Amended Regulation 4-2-11, Rate Filing and Annual Report Submissions Health Insurance, promulgated pursuant to the authority of Sections 10-1-109, 10-3-1110, 10-16-107(1), 10-16-107(1.5), and 10-16-109, C.R.S., states:

> Section 5. Rules
>
> Failure to supply the information required in Subsections 5(A)(4), 5(A)(5), 5(A)(7), 5(B)(1), 5(B)(2), 5(B)(3), and 5(B)(6) of this Section 5 will render the filing incomplete. Incomplete filings are not reviewed for substantive content. *All filings that are not returned on or before the 15th business day after receipt will be considered complete*. …[Emphasis added.]
>
> A. General Requirements
>
> 1. Required Submissions:
>
> a. All companies must submit rate filings whenever the actual premium amounts charged to the new or renewal policyholders or certificateholders change. …
>
> 2. Timing and Submission: Unless a filing is specifically identified as requiring prior approval (e.g. Medicare supplemental), all filings are classified as file and use. *File and use requires the company to file* the rates and rating data with the Division of Insurance concurrent with or prior to distribution, release to producers collection of premium, advertising, or any other use of the rate. …[Emphasis added.]

On 07/16/01, the Company filed a rate increase with the Division of Insurance to be implemented for renewal and new business for Plan A-3173. This rate increase was to be effective on 10/01/01. The rates were implemented for renewal business on 11/10/01, but were apparently not implemented on new business for which the Company continued to use previously filed rates of 04/01/01. In addition, it appears that American Republic did not notify the Colorado Division of Insurance that the rates filed for 10/01/01 were not implemented for new business.

It appears that the information in this rate filing and subsequent filing(s) was inaccurate in that it indicated the filed rates to be effective 10/01/01 had been implemented for both new and renewal business.

The state of Colorado is a "file and use" state, so the fact that the Company had not received confirmation of the filing to be implemented 10/01/01 for new and renewal business until after 10/01/01, should not have had any impact on whether or not the new rates were implemented.

Recommendation No. 18:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-11. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that filed rates are used for both new and renewal business as of the effective date stated in its filings as required by Colorado insurance law.

UNDERWRITING
CANCELLATIONS/NON-RENEWALS/DECLINATIONS
FINDINGS

Issue H1: Failure to provide CoverColorado notice forms in all required instances.

Section 10-8-503, C.R.S., Definitions, As used in this part 5, unless the context otherwise requires:

(17.3) "Program" or "CoverColorado" means CoverColorado and its administration and implementation of the health benefit plans permitted under this part 5.

Section 10-8-513, C.R.S., Eligibility for coverage under the program, states:

(1) Except for those individuals who meet the criteria set forth in subsection (2) of this section and except as provided in section 10-8-513.5, any individual who is a resident of this state, unless exempted by subsection (4) of this section, and who has been residing in the United States under the color of law for at least six months, including children who have been placed for adoption, as defined in section 10-16-104 (6.5) or are under the legal guardianship of a resident of Colorado, shall be eligible for coverage under the program, if such individual is able to provide evidence satisfactory to the administering carrier that such individual meets one of the following conditions:

(a) Such individual has applied to a carrier for a health benefit plan and:

(I) *Such application has been rejected or refused because of the health or medical condition of the applicant;* or [Emphasis added]

(II) Such application has been accepted, but at a premium rate exceeding the rate available through the program; or

(III) Such application was accepted with a reduction or exclusion of coverage for a pre-existing medical or health condition for a period exceeding six months.

(b) Such individual has a history of any medical or health condition that is on the presumptive conditions list adopted by the board pursuant to section 10-8-506(1) (g.5).

(c) Such individual has had a health benefit plan involuntarily terminated by a carrier in this state for any reason other than nonpayment of a premium or premiums.

Section 10-8-521, C.R.S., Notice to residents, states:

If any individual who is a resident of this state applies to a carrier for a health benefit plan and the carrier responds to such application as described in section 10-8-513(1)(a), or if any federally eligible individual applies to a carrier for a health benefit plan, the carrier shall give the individual written notice that the individual may be eligible for coverage under the program, including information about available benefits, exclusions, and premium subsidies, and the name, address, and telephone number of the program.

Amended Regulation 4-6-3, Concerning CoverColorado Standardized Notice Form And Eligibility Requirements, promulgated by the Commissioner of Insurance under the authority of §§ 10-1-109 and 10-8-520, C.R.S., states:

Section 4. Rules

B. Notification Requirements for Individuals with Adverse Underwriting Decisions

1. In order to comply with § 10-8-521, C.R.S., all carriers giving notice to an applicant or insured of one or more of the following adverse underwriting determinations shall be required to give notice to the applicant or insured that he or she may be eligible for coverage under CoverColorado. Dependents of participants are also eligible for coverage under the program. The adverse underwriting decisions which require the applicant/insurer to notify the applicant/insured are:

   a. The applicant is rejected for insurance because of the medical condition or history of the applicant; or

   b. The application was accepted, but the premium rate for insurance exceeds the rate available through CoverColorado; or

   c. Coverage will be reduced, limited by a restrictive rider or by the exclusion of coverage for a pre-existing condition for longer than six months.

2. Carriers shall be required to complete the CoverColorado Notice Form for every adverse underwriting determination listed above. Carriers may print the CoverColorado Notice Form on their own stationery but shall use the order, format and content of the CoverColorado Notice Form, as prescribed by the Commissioner of Insurance.

3. The carrier shall attach a copy of the CoverColorado Program Notice Form to the notice of adverse underwriting determination sent to an applicant for insurance. The carrier shall attach a copy of the Notice Form to a copy of the policy and endorsement when it is sent to the insured in the case of an individual being accepted for health insurance coverage but at a premium rate exceeding the rate available through the CoverColorado Program.

The Company provided a population of thirteen (13) policies that had been rescinded during 2002. Seven (7) of these files did not contain the CoverColorado Notice Form for Adverse Underwriting Decisions. These files are identified below:

RESCINDED FILES

Population	Sample	Number of Exceptions	Percentage to Sample
13	13	7	54%

A random sample of fifty (50) declined files was chosen for review. Eleven (11) of these files could not be classified as true declinations because the applicant withdrew the application for coverage prior to being declined by the Company. A determination was made that five (5) additional files were not true declinations because: two (2) involved add-on coverage; two (2) were for conversion coverage with

lesser benefits not requiring an application or underwriting, and one (1) had been entered in error. This reduced the sample of declined files to thirty-four (34). Eight (8) declined files in the sample of thirty-four (34) files were declined because of the medical condition of the applicant(s), however there is no evidence in these eight (8) files of the required notification for individuals with adverse underwriting decisions advising that the applicant(s) may be eligible for coverage under the CoverColorado program.

DECLINED FILES

Population	Sample	Number of Exceptions	Percentage to Sample
336	34	8	24%

Recommendation No. 19:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-8-513, 10-8-521, C.R.S., and Amended Regulation 4-6-3. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure compliance with Colorado insurance law in providing the CoverColorado Notice Form in all required instances.

Issue H2: Failure, in some cases, to issue Certificates of Creditable Coverage.

Amended Regulation 4-2-18, Concerning The Method of Crediting and Certifying Creditable Coverage For Pre-existing Conditions, promulgated by the Commissioner under the authority granted in Sections 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., states:

II. Purpose And Background

The purpose of this regulation is to establish the method health coverage plans must use to credit and certify creditable coverage when determining exclusions for pre-existing conditions as required by Section 10-16-118(1)(b), C.R.S. The purpose of the 1999 amendments to this regulation is to update the regulation as part of the Executive Order Review Process (Executive Order D0004 97).

V. Rules

A. Application of federal laws concerning creditable coverage

1. The method for crediting and certifying creditable coverage for determining pre-existing condition limitations, as required by Section 10-16-118(1)(b), C.R.S., shall be as set forth in federal regulations promulgated pursuant to HIPAA, with the following exceptions:

   a. Those exceptions specifically enumerated in this regulation; and

   b. Where Colorado law exists on the same subject and has different requirements that are not pre-empted by federal law, Colorado law shall prevail.

2. The federal regulations found in 45 C.F.R. 146.113(a)(3), (b) and (c); 45 C.F.R. 146.115; 45 C.F.R. 146.117; 45 C.F.R. 146.119(b); and 45 C.F.R. 146.125 (a)(3), (b) (d) and (e) adopted by the Department of Health and Human Services are hereby incorporated by reference, and shall have the force of Colorado law, in accordance with Section 24-4-103(12.5), C.R.S. These federal regulations concern methods of counting creditable coverage, requirements concerning a health plan's duty to provide certificates of creditable coverage to insureds, special enrollment periods, the effective dates for certification requirements, transition rules for counting creditable coverage, and transition rules for certificates of creditable coverage. This rule does not include later amendments to, or editions of, the above-referenced regulations. Interested parties are encouraged to refer to the summary and supplementary information concerning the incorporated regulations which begins in Volume 62, number 67, page 16894 of the Federal Register, April 8, 1997, for assistance in interpreting the federal regulations.

It appears that the Company did not issue certificates of creditable coverage to all insureds terminating coverage in 2002. There was no documentation of these certificates having been issued in eleven (11) of the sample of fifty (50) randomly selected cancelled/non-renewed files.

CANCELLED/NON-RENEWED FILES

Population	Sample	Number of Exceptions	Percentage to Sample
2,590	50	11	22%

Recommendation No. 20:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-18. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that Certificates of Creditable Coverage are issued, as required by Colorado insurance law, to all employees terminating medical coverage.

Issue H3: Failure, in some instances, to use non-discriminatory practices and use of unfair claim settlement practices in some instances involving rescission of coverage.

Section 10-16-201.5, C.R.S., Renewability of health benefit plans – modification of health benefit plans, states:

> (1) A carrier providing coverage under a health benefit plan shall not discontinue coverage or refuse to renew such plan except for the following reasons:
>
> (a) Nonpayment of the required premium;
>
> (b) *Fraud or intentional misrepresentation of material fact on the part of the* plan sponsor with respect to group health benefit plan coverage and the *individual with respect to individual coverage*; [emphases added.]

The examiners reviewed the total population of thirteen (13) files in which the Company had rescinded the insured's coverage during 2002. It appears that the Company is not in compliance with Colorado insurance law in that:

> One of the files was rescinded after the Company discovered that the applicant did not speak and understand English, and had been assisted by a relative in completing the application for coverage, and in providing information in a follow-up telephone interview.

There was no indication in the file that any of the information provided concerning the applicant was incorrect or misleading, and the presence of the relative during the completion of the application was disclosed to the Company by the agent. Therefore, it appears that the relative represented the applicant at the applicant's request, and that this would not represent a misrepresentation of a material fact that would justify rescinding the insured's coverage. Additionally, the Company's access plans indicate its efforts to address the needs of covered persons with limited English proficiency are handled in the following ways:

> American Republic Insurance Company agents are available to assist individuals with the application process. Language Line Services, a 24-hour, 7 days a week interpretation service, can be utilized if we do not have an interpreter available. All Customer Service Representatives are trained to utilize this service. Language Line Services provides interpretation services for over 140 different languages, including Spanish, Japanese, Chinese, and Vietnamese.

This appears to be a situation in which the agent knew there was a lack of English proficiency and at the time of application didn't use or alert the insured of the services the Company indicates are available for this type of situation.

RESCINDED FILES

Population	Sample	Number of Exceptions	Percentage to Sample
13	13	1	8%

Recommendation No. 21:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-201.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure, it does not discriminate in rescinding coverage as required by Colorado insurance law.

CLAIMS
FINDINGS

Issue J1: Failure, in some cases, to pay, deny or settle claims within the time periods required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

(2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

Paid and Denied Claims Received Electronically in 2002 Exceeding 30 Days

Data provided by the Company indicated a population of 9,293 paid and denied individual claims received electronically in 2002. The examiners identified eighty-six (86) claims from this population as taking over thirty (30) days from date of receipt to process. The population of eighty-six (86) files was used for the sample. Thirty-two (32) of these claims do not appear to have been processed as required by Colorado insurance law with respect to the allowed time frame.

PAID AND DENIED ELECTRONIC CLAIMS OVER 30 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
86	86	32	37%

(<1% of all paid and denied electronic claims)

Paid and Denied Claims Received Non-Electronically in 2002 Exceeding 45 Days

Data provided by the Company indicated a population of 8,846 paid and denied individual claims received non-electronically in 2002. The examiners identified eighty-eight (88) claims from this population as taking over forty-five (45) days from date of receipt to process. The population of eighty-eight (88) files was used for the sample. Twenty-nine (29) of these claims do not appear to have been processed as required by Colorado insurance law with respect to the allowed time frame.

PAID AND DENIED NON-ELECTRONIC CLAIMS OVER 45 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
88	88	29	33%

(<1% of all paid and denied non-electronic claims)

Paid and Denied Claims Received in 2002 Exceeding 90 Days

Data provided by the Company indicated a population of 12,927 paid individual claims and 5,212 denied individual claims received in 2002. The examiners identified twenty-three (23) claims from this combined population of 18,139 as taking over ninety (90) days from date of receipt to process. None of these twenty-three (23) claims appeared to involve fraud. These claims do not appear to have been paid, denied or settled as required by Colorado insurance law with respect to the ninety (90) day time frame.

CLAIMS NOT PAID, DENIED OR SETTLED WITHIN NINETY (90) DAYS

Population	Sample Size	Number of Exceptions	Percentage to Population
23	N/A	23	100%

(<1% of all paid and denied claims)

Recommendation No. 22:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that all claims are paid, denied or settled within the time periods required by Colorado insurance law.

Issue J2: Failure to accurately determine the number of days utilized for claim processing.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

> (4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.
>
> (b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).
>
> (c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

Section 10-16-121, C.R.S., Required contract provisions in contracts between carriers and providers, states:

> (1) A contract between a carrier and a provider or its representative concerning the delivery, provision, payment, or offering of care or services covered by a managed care plan shall make provisions for the following requirements:
>
> (b) Any contract providing for the performance of claims processing functions by an entity with which the carrier contracts shall require such entity to comply with section 10-16-106.5 (3), (4), and (5).

The data being entered into the Company's claim system and used for computing the days from receipt of a paper (non-electronically) received claim until the check/explanation of benefits is mailed to the claimant (processing time) appears to be producing an incorrect number of days as indicated by the following procedures:

1. In Colorado, the Company may use any of the following repricing entities:

    - Sloans Lake Managed Care
    - Mountain Medical Affiliates, Inc.
    - BCE Emergis Corporation-Ehealth Solutions Group
    - First Health Group Corporation

The insured's identification (ID) card reflects the address to be used by medical providers for paper claims submissions. The ID cards for both Sloans Lake Managed Care and Mountain Medical Affiliates, Inc., reflect that claims are to be mailed to each of these repricers. The Company has indicated that claims received directly by a PPO network are forwarded to American Republic for processing after the claim has been repriced and the receipt date used for claims processing is the date American Republic receives the repriced claim from the PPO network.

For electronic claim submissions, WebMD, a claims clearinghouse, records a receipt date on every claim as the date they received the claim submission from the provider. The same received date on the electronic file transmission passed to American Republic is used as the receipt date by American Republic.

2. The process date being entered in the Company's system and used to compute the processing time for both paper and non-electronically submitted claims is the date the claims system adjudication is completed by the claims examiner. An outside vendor is used to print and mail claim drafts and explanations of benefits (EOBs) Claims information is electronically transmitted to the vendor, and during 2002, checks and EOBs were printed and mailed on Tuesdays and Thursdays. In order to account for the delay between process date and check issued date, the Company created "interest add-on days" procedures that they update periodically to reflect holiday dates and changing business practices. Claims examiners referred to a chart to determine how many days they needed to add to the total processing time in order to ensure that the correct amount of interest, if applicable, was included in the claims payment. Although it appears that this chart would allow the Company to determine the amount of interest to be paid once a claim exceeded the appropriate time period (30 or 45 days), it does not appear that it would provide an accurate trigger of when a claim is not completed on time if that is being based on the processing time in the system.

These two procedures being used by the Company appear to result in an inability to accurately track the number of days utilized for processing of claims and to determine in all instances those for which late payment interest and penalties would apply. Carriers cannot avoid their statutory obligations regarding the amount of time allowed for processing claims without interest/penalty being due because an intermediary repricer is involved.

Recommendation No. 23:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-106.5 and 10-16-121, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established the necessary procedures to ensure compliance with Colorado insurance law in accurately determining the number of days used to process claims.

Issue J3: Failure, in some instances, to pay late payment penalties on claims.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

(4)(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5)(b) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.

CLAIMS NOT PAID, DENIED OR SETTLED WITHIN NINETY (90) DAYS

Population	Sample Size	Number of Exceptions	Percentage to Population
23	N/A	23	100%

(<1% of all paid and denied claims)

The examiners reviewed the entire population of twenty-three (23) claims that were not paid, denied, or settled within the required ninety (90) day time period. It appears that the Company is not in compliance with Colorado insurance law in that none of the files indicated that late payment penalties had been paid on these claims.

Recommendation No. 24:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that late payment penalties are paid in all applicable instances as required by Colorado insurance law.

Issue J4: Failure to have available a mechanism for providers to confirm receipt of a claim or to determine if resubmission of a claim is necessary.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

> (2.7)(b)(I) A carrier shall make a mechanism available to providers that shall enable a provider to confirm the receipt of a claim that is filed with the carrier in a manner other than electronically. Within ten business days after the submission of the claim as determined by the provider, the carrier shall list such claim on the notification mechanism as received. The claim shall be deemed received on the date it is listed on the notification mechanism by the carrier. If a claim is not listed on the notification mechanism, the provider may contact the carrier for the purposes of resubmission of the claim. The carrier shall have a separate facsimile process to receive the resubmission of the paper claims. The resubmitted claim shall be deemed received on the date of the facsimile transmission acknowledgment. If such mechanism is accessible only by electronic means, upon request of the provider, the information must be made available in hard-copy form within three business days.

The Company has indicated it uses the following process for compliance with Colorado insurance law in making a mechanism available to providers to enable them to confirm the receipt of claims filed in a manner other than electronically.

> It is American Republic's process to send a written acknowledgment (a.k.a. "mechanism") within ten (10) business days of *its* receipt of a non-electronic claim. [Emphasis added.] Claims received from either PPO intermediary, Sloans Lake Managed Care or Mountain Medical Affiliates, are included in this process once the claim is received by the carrier, i.e., American Republic. The written acknowledgement process is a system-automated process for all Colorado claims, and is not included in our claims procedure manual.

This process does not appear to meet the requirement of a mechanism available to providers to confirm the correct receipt date of a non-electronically submitted claim and for resubmission of the claim if determined necessary in the following ways:

1. The claim is to be listed on a mechanism within ten (10) business days after submission (as determined by the provider) and the claim shall be deemed received on the date it is listed on the notification mechanism. These claims are initially received by the Company's PPO intermediaries and forwarded to the carrier at which time the written acknowledgment ("mechanism") is sent. This results in an incorrect receipt date being given to the providers.

2. A provider is not being given access to a mechanism for confirming receipt as this is an action controlled by the Company. If a provider doesn't receive an acknowledgement letter, there needs to be a mechanism for him/her to confirm receipt (or not).

3. The requirement for a provider being able to determine if a claim is not listed on the notification mechanism, and using a separate facsimile process maintained by the Company for resubmission of the claim would not be available.

Recommendation No. 25:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that a mechanism is in place that enables providers to confirm receipt of a claim or determine if resubmission of a claim is necessary as required by Colorado insurance law.

UTILIZATION REVIEW FINDINGS

Issue K1: Failure to reflect correct or complete information for second level appeals or external review rights.

Amended Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(3)(b) and 10-16-109, C.R.S., states:

Section 4. Definitions [2]

C. "Clinical peer" means a physician or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

Section 8. Appeals of Adverse Determinations

For purposes of this section, "covered person" includes the designated representative of a covered person.

I. Standard Appeals

B. Second Level Appeal Review

3. A health carrier's procedures for conducting a second level panel review shall include the following:

a) …Whenever a covered person has requested the opportunity to appear in person before authorized representatives of the health carrier, the review meeting shall be held during regular business hours at a location reasonably accessible to the covered person, including accommodation for disabilities. Carriers shall in no way discourage a covered person from requesting a face-to-face review meeting. In cases where a face-to-face meeting is not practical for geographic reasons, a health carrier shall offer the covered person the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, video conferencing, or other appropriate technology. The covered person shall be notified in writing at least fifteen (15) working days in advance of the review date. The health carrier shall not unreasonably deny a request for postponement of the review made by a covered person.

b) Upon the request of a covered person, a health carrier shall provide to the covered person all relevant information that is not confidential or privileged under state or federal law.

c) A covered person has the right to:

(1) Attend the second level review;

(2) Present his or her case to the review panel in person or in writing;

(3) Submit supporting material both before and at the review meeting;

(4) Ask questions of any representative of the health carrier prior to the hearing and question any panelist at the hearing; and

(5) Be assisted or represented by a person of his or her choice.

d) *The notice shall advise the covered person of the rights specified in this section 8.I.B;*. [Emphasis added.]

g) The review panel, after private deliberation, shall issue a written decision to the covered person *within five (5) working days of completing the review meeting*. [Emphasis added.]

II. Expedited Appeals

A health carrier shall establish written procedures for the expedited review of an adverse determination involving a situation where the time frame of the standard review procedures set forth in Section 8.I.A or B would seriously jeopardize the life or health of the covered person, would jeopardize the covered person's ability to regain maximum function, or, *for persons with a disability, create an imminent and substantial limitation on their existing ability to live independently. ...*

New Regulation: 4-2-21, External Review of Benefit Denials of Health Coverage Plans, promulgated and adopted by the commissioner of Insurance under the authority of §10-1-109, 10-16-109, 10-16-113(3)(b) and 10-16-113.5(4)(d), C.R.S., states:

Section 5. Notice and Disclosure of Right to External Review

A. (1) A carrier shall notify the covered person in writing of the covered person's right to request an external review and include the appropriate statements and information set forth in (2) of this subsection A at the time the carrier sends written notice of carrier's final adverse determination.

(2) The carrier shall include in the required notice *a copy of the description of both the standard and expedited external review procedures the carrier is required to provide pursuant to Subsection B, including the provisions in the external review procedures that give the covered person or the covered person's designated representative the opportunity to submit new information and including any forms used to process an external review, as specified by the Division of Insurance.* [Emphasis added.]

Section 8. Standard External Review

B. (2) After notice from the commissioner pursuant to (1) of this Subsection B, the carrier shall notify within two (2) working days the covered person or the designated representative, electronically, by facsimile, or by telephone, followed by a written confirmation. The notice shall include a written description of the independent external review entity that the commissioner has selected to conduct the external review and information regarding how the covered person or the designated representative may provide the commissioner with documentation regarding any potential conflict of interest of the independent external review entity as described in Section 12 of this regulation.

(3) Within two (2) working days of receipt of notice from the carrier, the covered person or the designated representative may provide the commissioner with documentation regarding a potential conflict of interest of the independent external review entity, electronically, by facsimile, or by telephone, followed by a written confirmation. If the commissioner determines that the independent external review entity presents a conflict of interest as described in §10-16-113.5(4)(b), C.R.S., the commissioner shall assign, within one (1) working day, another independent external review entity to conduct the external review that has been approved pursuant to Section 11 of this regulation. …

C. (3)(a) The certified independent external review entity shall notify the covered person or the designated representative, the health care professional of the covered person, and the carrier of any additional medical information required to conduct the review after receipt of the documentation required pursuant to Paragraph (1) of this Subsection C. Within five (5)working days of such a request, the covered person or the designated representative or the health care professional of the covered person shall submit the additional information, or an explanation of why the additional information is not being submitted to the certified independent external review entity and the carrier.

H. (4) Upon carrier's receipt of the independent external review entity's notice of a decision pursuant to Paragraph (1) of this Subsection H reversing the carrier's final adverse determination, the carrier shall approve the coverage that was the subject of the carrier's final adverse determination. For concurrent and prospective reviews, the carrier shall approve the coverage within one (1) working day. For retrospective reviews, the carrier shall approve the coverage within five (5) working days. The carrier shall provide written notice of the approval to the covered person or the designated representative within one (1) working day of the carrier's approval of coverage. The coverage shall be provided subject to the terms and conditions applicable to benefits under the health coverage plan.

Section 9. Expedited External Review

A. (1) Except as provided in Subsection I of this Section 9, *a covered person or the covered person's designated representative may make a request for an expedited external review* with the carrier if the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to Section 8 of this regulation would seriously jeopardize the life or health of the covered person, would jeopardize the

covered person's ability to regain maximum function or, for persons with a disability, create an imminent and substantial limitation of their existing ability to live independently. [Emphasis added.]

(2) The covered person's or the designated representative's request for an expedited review *must include a physician's certification that the covered person's medical condition meets the criteria in Paragraph (1) of this Subsection A*. [Emphasis added.]

E. The certified independent external review entity shall notify, electronically, by facsimile, or by telephone followed by a written confirmation, the covered person or designated representative, the health care professional of the covered person, and the carrier of any additional medical information required to conduct the review after receipt of the documentation required pursuant to subsection D of this Section 9. The covered person or designated representative or the health care professional of the covered person shall submit the additional information, or an explanation of why the additional information is not being submitted to the certified independent external review entity and the carrier within two (2) working days of such a request.

H. (4) Upon carrier's receipt of the independent external review entity's notice of a decision pursuant to Paragraph (1) of this Subsection H reversing the carrier's final adverse determination, the carrier shall approve the coverage that was the subject of the carrier's final adverse determination within one (1) working day. The carrier shall provide written notice of the approval to the covered person or the designated representative within one (1) working day of receipt of the notice pursuant to Paragraph (1) of this Subsection H. The coverage shall be provided subject to the terms and conditions applicable to benefits under the health coverage plan.

I. An expedited external review may not be provided for retrospective adverse determinations.

Bulletin No. 7-00, issued March 10, 2000

Independent External Reviews for Denials of Health Claims

I. PURPOSE

The purpose of this bulletin is to specify the forms to be utilized in conjunction with processes related to independent external reviews of health claim denials pursuant to Division of Insurance Regulation 4-2-21.

II. NECESSARY ACTION

The following forms shall be used to request independent external reviews, apply to be certified as an independent external review entity, and to comply with annual reporting requirements of carriers and independent external review entities about external review activities.

1. Appendix A is the form to be used for consumers to request an independent external review following a carrier's final adverse determination pursuant to Division of Insurance Regulation 4-2-17.

The Company uses ENCOMPASS Health Management Systems to conduct Utilization Review. The notification letter of an adverse determination on a Standard First Level Appeal Review used by ENCOMPASS advises the insured to contact their insurance carrier to ensure that all internal appeals have been completed prior to requesting an external appeal. If the insured or the insured's authorized representative contacts American Republic Insurance Company, the Company's Administrative Compliance Department would notify them of their right to a second-level grievance review. If a Second Level Appeal Review is performed and the initial decision is upheld, the notification letter to the insured and/or their representative directs them to the Company's Administrative Compliance Department to request an external review. The document, titled "Colorado Grievance Procedures", used by American Republic and provided to the insured or their representative with a description of second level review and external review rights does not appear to be correct or complete in the following ways:

Incomplete

1) The definition of a Clinical Peer in this document does not reflect that the physician or health care professional's non-restricted license is to be in a state of the United States.

2) The document advises of the covered person's right to request a standard independent external review, but does not include the form used to request an independent external review of the carrier's final adverse determination.

3) The description of situations allowing an internal expedited appeal does not include persons with a disability for whom the time frame of the standard review procedures would create an imminent and substantial limitation on their existing ability to live independently.

4) The description of a Second Level Appeal review does not reflect the following rights of the covered person.

- To attend the second level review
- To present his or her case to the review panel in person or in writing
- To submit supporting material both before and at the review meeting
- To ask questions of any representative of the health carrier prior to the hearing and question any panelist at the hearing
- To be assisted or represented by a person of his or her choice
- To request and to be provided all relevant information that is not confidential or privileged under state or federal law

5) The document does not reflect that all requests for external review shall include a signed consent authorizing the carrier to disclose protected health information, including medical records, concerning the covered person that is pertinent to external review.

6) The document's description of an External Review does not contain the timelines and procedures listed below that should be included in the description and relayed to the insured:

- The time frames with regards to notification to the covered person or designated representative of the independent external review entity selected by the commissioner and the right of the covered person or designated representative to provide the commissioner with documentation regarding any potential conflict of interest.
- The time frames within which the covered person or designated representative are required to submit any additional information or an explanation of why the additional information is not being submitted pursuant to a request by the certified independent external review entity and the carrier.
- There is no description of the timelines required of the carrier for approving coverage for concurrent, prospective and retrospective reviews in the event of the external review entity's notice of a decision to reverse the carrier's final adverse determination.

7) The document's description of an Expedited External Review does not contain the timelines and procedures listed below that should be included in the description and relayed to the insured.

- Nothing is reflected concerning the requirement that a request for an expedited review must include a physician's certification that the covered person's medical condition meets certain criteria.
- There is no description of the timelines required of the carrier for approving coverage upon receipt of an independent external review entity's decision to reverse the carrier's final adverse determination.
- Nothing is reflected in the description to indicate that an expedited external review may not be provided for retrospective adverse determinations.
- The time frames within which the covered person or designated representative are required to submit any additional information or an explanation of why the additional information is not being submitted pursuant to a request by the certified independent external review entity and the carrier.

Incorrect

1) The description contained in this document of the rights of the insured or their representative in a second level appeal review is incorrect in stating

that neither the insured nor the representative may attend the second level appeal review. This is a right expressly stated in Colorado insurance law and is in no way to be discouraged.

2) The document reflects that a written decision will be provided by the review panel within 15 working days after completing the second level appeal review meeting. This written decision is to be provided within 5 working days after completing the review meeting.

3) The description of the External Expedited Review Request includes the covered person's health care provider as someone who may file a written request to initiate an external expedited review and only a covered person or the covered person's designated representative may make this request.

Wording in the Company's document notifying the insured and their representative, if applicable, of second level review and external review rights reflects the following:

COLORADO GRIEVANCE PROCEDURES

CLINICAL PEER means a doctor or other health care professional who holds a nonrestricted license in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.

Internal Expedited Review Request…If you have a situation where the time frame of the standard grievance review process would seriously threaten your life, health or ability to regain maximum function, you, your representative or your health care provider may request an expedited review by telephone. We will notify you, your representative or your health care provider by telephone or by facsimile of our decision and provide all necessary information.

Second-Level Grievance Review…Neither you or your representative may attend the second-level grievance review; however, you are entitled to submit written material, and will be provided with necessary instructions.

Second-Level Grievance Review…A written decision will be provided by the review panel within 15 working days after completing the review meeting.

External Expedited Review Request…You, your representative or your health care provider may file a written request to initiate an external expedited review.

Recommendation No. 26:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17 and New Regulation: 4-2-21. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that as required by Colorado insurance law, correct and complete information is provided to insureds concerning second level utilization review appeals and external review rights.

Issue K2: Failure to include all required information in notification letters for first level appeal determinations.

Amended Regulation 4-2-17, Prompt Investigation Of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(3)(b) and 10-16-109, Colorado Revised Statutes (C.R.S.), states:

> **Section 8. Appeals of Adverse Determinations**
>
> I. A. First Level Appeal Review
>
> 3. For standard appeals the health carrier shall notify in writing both the covered person and the attending or ordering provider of the decision within twenty (20) working days following the request for an appeal. The written decision shall contain:
>
> a) The *name*, title and qualifying credentials of the physician evaluating the appeal, *and the qualifying credentials of the clinical peer(s)* with whom the physician consults. (For the purposes of this section, the physician and consulting clinical peers shall be called "the reviewers."); [Emphases added.]
>
> b) A statement of the reviewers' understanding of the reason for the covered person's request for an appeal;
>
> d) A reference to the evidence or documentation used as the basis for the decision, including the clinical review criteria used to make the determination, *and instructions for requesting the clinical review criteria;* and [Emphasis added.]
>
> e) A *description of the process* for submitting a grievance in writing requesting a further, *second level appeal review* of the case. [Emphases added.]

The Company uses Encompass Health Management Systems to perform Utilization Review on their behalf. The copy of a written notification letter for First Level Appeal determinations that was provided to the examiners for review does not appear to be in compliance with Colorado insurance law in that the letter does not contain the following required items:

The name of the physician evaluating the appeal or the qualifying credentials of the consulting clinical peer(s) with whom he consults

Statement of the reviewers' understanding of the reason for the appeal

Instructions for the covered person to request the clinical review criteria used as the basis of the determination

A description of the process for requesting a further second level appeal review of the case

Recommendation No. 27:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that notification letters for first level appeal reviews contain all information as required by Colorado insurance law.

SUMMARY OF ISSUES AND RECOMMENDATIONS

ISSUES	Rec. No.	Page No.
COMPANY OPERATIONS/MANAGEMENT – FINDINGS		
Issue A1: Certifying and using forms that do not comply with Colorado insurance law.	1	17
UNDERWRITING – POLICY FORMS – FINDINGS		
Issue E1: Failure to include a complete description of the independent external review procedures in or attached to the policy.	2	20
Issue E2: Failure to reflect only allowable reasons for non-renewal of plans.	3	22
Issue E3: Failure of the forms to provide benefits for covered services based on a provider's status as a family member.	4	23
Issue E4: Failure to reflect correct information in a policy provision required for individual policies.	5	25
Issue E5: Failure to reflect required information in application and notice forms concerning replacement of accident and sickness coverage.	6	29
Issue E6: Failure to reflect a correct definition of a Business Group of One in an Applicant Disclosure form.	7	31
Issue E7: Failure to reflect correct or complete information in the CoverColorado Notice Form.	8	34
Issue E8: Failure to reflect correct and complete coverage to be provided for home health care services.	9	37
Issue E9: Failure to reflect correctly and completely the extent of coverage to be provided for hospice care services.	10	43
Issue E10: Failure to disclose the mandated hospitalization and general anesthesia benefit for dental procedures for dependent children.	11	45
Issue E11: Failure to reflect that repairs and replacement of prosthetic devices, unless due to misuse or loss, are to be covered.	12	46
Issue E12: Failure to reflect complete mandated preventive child health supervision service benefits.	13	48
Issue E13: Failure to reflect an accurate or complete description of the mandated therapies for congenital defects and birth abnormalities for children.	14	50
Issue E14: Failure to provide coverage for routine hospital nursery care for newborns.	15	52
Issue E15: Failure to reflect an accurate description of the mandated coverage for prostate cancer screening.	16	54
Issue E16: Failure to reflect correct benefits for mammography screening.	17	57
UNDERWRITING - RATING		
Issue F1: Failure, in some instances, to use the rates filed with the Colorado Division of Insurance.	18	60
UNDERWRITING - CANCELLATIONS/NON-REN/DECLINATIONS		
Issue H1: Failure to provide CoverColorado notice forms in all required instances.	19	64

ISSUES	Rec. No.	Page No.
Issue H2: Failure, in some cases, to issue Certificates of Creditable Coverage.	20	66
Issue H3: Failure, in some instances, to use non-discriminatory practices and use of unfair claim settlement practices in some instances involving rescission of coverage.	21	68
CLAIMS – FINDINGS		
Issue J1: Failure, in some cases, to pay, deny or settle claims within the time periods required by Colorado insurance law.	22	71
Issue J2: Failure to accurately determine the number of days utilized for claim processing.	23	73
Issue J3: Failure, in some instances, to pay late payment penalties on claims.	24	74
Issue J4: Failure to have available a mechanism for providers to confirm receipt of a claim or to determine if resubmission of a claim is necessary.	25	76
UTILIZATION REVIEW - FINDINGS		
Issue K1: Failure to reflect correct or complete information for second level appeals or external review rights.	26	85
Issue K2: Failure to include all required information in notification letters for first level appeal determinations.	27	87

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